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ABSTRACT

This ethnographic study examines the treatment of first-generation Puerto Rican migrants at a mental health center specializing in services to Hispanic Americans. Information was gathered from observation of staff activities and interviews with staff and residents of the surrounding community. The center, located in a low-income Puerto Rican neighborhood, is easily accessible and reflects the cultural background of the people it serves. All staff are bilingual and bicultural. The following findings are highlighted: (1) therapists use alternative healing practices, such as spiritism, which provide comfort to clients and promote therapy; (2) food is an integral part of the treatment program because it represents greeting and acceptance in the Latino culture; (3) clients frequently face problems common to other economically disadvantaged groups; (4) service activities go beyond traditional counseling, including assistance in finding housing and financial aid; and (5) clients are taught the customs and ways of North American culture within the therapeutic relationship, including value orientation, acculturation, and advocacy. Four case studies are included. A 79-item bibliography is appended. (FMW)

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Monograph No. 1

A STUDY OF THE MENTAL HEALTH TREATMENT OF THE PUERTO RICAN MIGRANT

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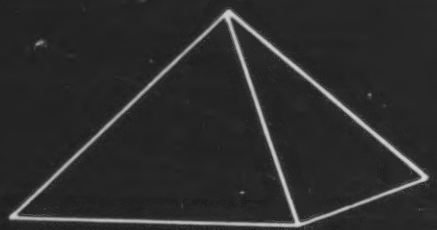

Jose Reyes
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A STUDY OF THE MENTAL HEALTH TREATMENT OF PUERTO RICAN MIGRANTS

Monograph No. 1

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The Minority Education, Research and Training Institute at Metropolitan Hospital, Community Mental Health Center, New York City Health and Hospitals Corporation, in affiliation with New York Medical College, New York City, New York.

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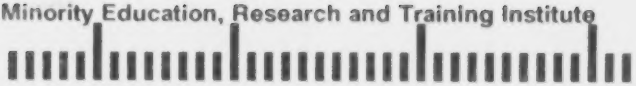

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FOREWORD

The study of the Puerto Rican migrant family is an area that has received some considerable attention since the influx of Puerto Ricans to the continental United States in the late 1940's. Although there is a significant amount of literature regarding this unique group of immigrants, not enough has been written about "what" treatment programs actually do in providing services to Puerto Ricans, in particular and Hispanics, in general.

The Minority Education, Research and Training Institute, MERTI, has recognized that the literature is replete with statements of what should be or could be done. There is an obvious need to pursue an expanded approach by focusing on the actual services being provided by successful programs servicing Puerto Rican and Hispanic clients. We are fortunate that MERTI has a long standing relationship with just such a program, the Roberto Clemente Family Guidance Center. We are also fortunate that a MERTI research fellow had similar interests. The ethnographical approach, utilized by Dr. Jose Reyes for this particular goal, was not only timely, but appropriate in order to document those therapeutic practices that makes an agency excel and to stand as a national model program.

Some significant highlights of this study include: 1) the general acceptability by therapists of alternative healing practices such as spiritism, and its supportive approach by providing comfort and encouraging therapy along with continued folk healing practices, 2) the importance of food as an integral part of the treatment program approach which is reflective of greeting and acceptance within the Latino culture, 3) case vignette presentations which reflect some of the more typical problems of families in a poor environment as an adjunct to the therapeutic techniques utilized by bilingual staff in providing family therapy, 4) service activities that go beyond traditional counselling, and 5) the importance of

exploring and teaching clients the customs and ways of the North American culture within the therapeutic relationship, including value orientation, acculturation, and advocacy within bureaucratic organizations.

In conclusion, I hope that the ethnographical approach presented in this monograph imparts an enlightened perspective for the new therapist and a reawakening for those of us who continue to seek more appropriate treatment approaches and techniques in working with multiproblematic, poor, Puerto Rican and Hispanic migrant families.

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ABOUT MERTI

The Minority, Education, Research and Training Institute, at the Metropolitan Hospital Community Mental Health Center was established in 1988 through the efforts of Phyllis Harrison-Ross, M.D. and the Minority Advisory Council to the New York State Office of Mental Health.

MERTI seeks to provide guidance and support to the New York State Office of Mental Health in its continuing efforts to structure a system of care that best meets the needs of all citizens, especially minorities and the poor. To this end, initiatives in training and research that meet the following criteria are encouraged and considered for support:

- Advancement of the competency, skills, and career opportunities of minority group providers.
- Improvement of the mental-health system, specifically as it impacts on minority group patients.
- Advancement of minority mental health scientific knowledge.

Through the MERTI Fellowship Program, support is provided to qualified minority professionals to further their training in their areas of specialization and to conduct research, evaluation, or clinical projects of scientific interest and merit. Additionally, MERTI disseminates information through various mechanisms that include papers, monographs, and training conferences.

ABOUT THE AUTHOR

Jose Reyes was born on February 17, 1957 in Bayamon, Puerto Rico. In 1971, he migrated with his family to the United States where he graduated from John F. Kennedy High School in 1975. After attending the Universidad del Sagrado Corazon in Santurce, Puerto Rico, for two years, he graduated from Evangel College, Springfield, Missouri, with a double major in Psychology and spanish Literature and a minor in Sociology.

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Dr. Inclan received his B.S. degree from Georgetown University and his Ph.D. degree in clinical psychology from New York University. He has published various articles and has lectured world-wide in the area of family/marital therapy and cross cultural issues in mental health. He is a board member of the American Family Therapy Association and past board member of the American Orthopsychiatric Association. He has served in numerous health and mental health committees and has presented testimony to various U.S. Congressional health committees. He is also a consultant to professional groups and schools including the Robert Louis Stevenson School.

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We at MERTI would like to thank our supportive staff which have worked very diligently with the publication of this monograph. Special thanks and appreciation to Evelyn Tenju Dent, Alexandrina Medina and to Noemi Colon for their preliminary activities in the initial drafts, and to Malik Abdur-Razzaq and Rajan Somasundaran for the initial set up, technical assistance and maintenance of the computer hardware/software programs.

CHAPTER I

INTRODUCTION

The mental health treatment of Hispanic migrants in the United States has been a topic of growing concern for mental health practitioners in major metropolitan areas. The number of Hispanics migrating to this country continues to increase, and a large percentage of this number are Puerto Rican.

Documentation of Puerto Rican migration to the United States began in the early 1890s. Migration, however, started earlier when the United States government offered employment for Puerto Rican sugar cane workers in the plantations of the South. Following the invasion and colonization of Puerto Rico by the United States in 1898, migration increased considerably. According to the 1980 census report, there were 2,013,945 Puerto Ricans living in the United States, an increase of 584,549 over the 1970 census figure.

Most Puerto Ricans who migrate to the United States do so for economic reasons. For example, the 1980 census showed that, in 1979, 50 percent of families in Puerto Rico had incomes below the poverty level; the island had a mean family income of $8,271 per year and a 29 percent unemployment rate. It is no wonder, then, that many Puerto Rican migrants see the United States as the land of opportunity. In addition, most Puerto Ricans migrate to metropolitan areas, with nearly 50 percent of the total Puerto Rican population in the United States residing in New York City (Mann and Salvo, 1984).

Migration has been recognized as a process which produces stress and a sense of loss (Arredondo-Dowd, 1980). There is ample evidence (Inclan, 1984, 1985) that the sharp contrasts in the values and expectations found in the Anglo and Puerto Rican cultures account for many of the psychological and psychosocial conflicts confronted by the Puerto Rican living in the United States. During this period of transition to a new culture added emotional support is often necessary to help deal with psychological,

social and environmental changes.

The literature on mental health and the Puerto Rican migrant focuses on the development of methods and techniques which make the delivery of mental health services more relevant to the needs of this population. This focus has emerged from research which shows that the Puerto Rican migrant has a significantly lower level of utilization of mental health services when compared with the general population. Thus, the effort to understand why the Puerto Rican migrant is less likely to utilize mental health services has given rise to speculations on what could be done to improve services. However, little emphasis has been placed on investigating the provision of actual services.

The present research, conducted as an ethnographic study, was designed to examine a mental health center which was established to provide relevant clinical services to first-generation Hispanic migrants. The study focuses on the actual delivery of services by staff at the center and has an anthropological perspective in that it seeks to describe and communicate the culture of the center, with culture viewed as a system of interrelated parts.

The ethnographic findings presented in this study and the research techniques and instruments used in the fieldwork were determined by a process of inquiry referred to in the literature as the researcher's point of view (Erickson, 1984). The process of inquiry in this study was developed as the result of information gathered in the field, the author's experiences as a participant observer and a review of the literature dealing with mental health treatment of the Hispanic migrant.

The primary aim of the study is to describe the overall functioning of the center, including its organizational structure, types and profiles of clients and profiles of staff. The research then focuses on the type of treatment delivered at the center. This focus was particularly necessary since the literature on the treatment of the Puerto Rican migrant is devoid of descriptions of

culturally relevant services currently being offered. The description of the treatment provided by the center was derived from observation of the actual delivery of therapy by the treatment staff and of therapy sessions through a one-way mirror. These observations then formed the basis of interviews with the treatment staff focusing on their interpretation of the treatment they provide to clients.

The rationale for this type of study is derived from the literature on the treatment of the Puerto Rican migrant and mental health. This literature, reviewed in Chapter II, focuses on the problems associated with utilization of mental health services by the Puerto Rican migrant and models which have been suggested in the literature to make services more attractive.

Chapter III discusses the methodology used for gathering and analyzing the data.

Chapter IV describes the center, its staff and therapeutic structure. This chapter also presents the culture of the center and compares characteristics of the center's culture with those of the migrants who seek services.

Chapter V presents samples of actual therapy sessions, including the themes discussed by clients in therapy. This chapter also describes the therapeutic approach used by therapists in these sessions.

Chapter VI presents the results of interviews conducted with the therapists regarding their therapeutic approach with clients at the center.

Finally, Chapter VII integrates findings and discusses the implications of creating a culturally relevant therapeutic program for Hispanic migrants.

CHAPTER II

THE PROVISION OF MENTAL HEALTH SERVICES TO THE PUERTO RICAN MIGRANT

The literature on the mental health treatment of the Puerto Rican migrant points to one general problem: the underutilization of services. This means that the Puerto Rican migrant does not seek mental health services when needed and/or tends to drop out of treatment when started. Furthermore, the literature asserts that underutilization of mental health services exists despite the availability of services (Ahearn, 1979; Christensen, 1977; Rogler, 1979). Even for those migrants who initially utilize services, there is a 65 percent attrition rate (Morales-Dorta, 1976).

Underutilization of Mental Health Services

There are three predominant views to explain the underutilization of mental health services by the Puerto Rican migrant. The first view holds that the lack of Spanish-speaking personnel makes mental health treatment unattractive to the migrant, possibly leading to decreased comfort with the services. Marcos, Alpert, Urcuyo and Kesselman (1973) found that migrants had difficulty in benefiting from catharsis, since verbalization of feelings in English, the migrant's second language, often turns out to be a burdensome intellectual task, bringing little relief to the Puerto Rican client. This research suggests that the use of bilingual personnel makes treatment more attractive for the migrant.

A second view suggests that most mental health practitioners are not bicultural and therefore not sensitive to the problems, issues and solutions unique to the Puerto Rican migrant. Delgado (1982) stated that direct service providers often fail to understand culturally specific issues and, consequently, misinterpret native strengths of the migrant's environment as liabilities.

Finally, a third position holds that there is a limited

provision of services effective for dealing with the needs of the migrant. Specifically, social class variables often determine physical and mental health. Generally, ethnic minorities have significantly low levels of housing, education, occupation and income. These conditions are thought to be predisposing factors in psychological, emotional and physical health problems (De La Cancela, 1985a).

Problems in treatment often arise from these social class variables and result in either premature termination or nonutilization of services. These social class factors include environmental and financial constraints, such as not being allowed to take time off from work to attend treatment, the cost of being absent from work to attend treatment and the cost of transportation to attend treatment. Other important social class factors are the social distance between the therapist and the client and treatment interventions aimed at psychodynamic conflicts to the exclusion of environmental and social interventions geared toward the alleviation of poverty-related problems (De La Cancela, 1985a; Galper, 1978).

Regardless of which view is held to explain why Puerto Ricans do not seek or attend mental health services, there is evidence that mental health problems do exist for this population. One study found that Puerto Ricans have a higher rate of mental illness when compared with other Hispanic groups (Malzberg, 1962). Another study indicated that first-time psychiatric hospitalizations for Puerto Ricans were three times higher than those for the general population (Fitzpatrick and Gould, 1970). This high rate of hospitalization can be interpreted as a result of the lack of culturally specific, preventive mental health services available to the migrant.

Research also points to the high incidence of hospitalization for the Puerto Rican migrant as indicative of the high incidence of schizophrenia found among this population when compared with other minority groups (Fitzpatrick and Gould, 1968; Rogler and Hollingshead, 1965).

Misdiagnosis

Minorities in general tend to get labeled with more severe psychiatric diagnoses. Hollingshead and Redlich (1958) found social class to be an appropriate indicator of treatment and diagnosis of mental illness. This study found that people of a lower social class are diagnosed as having more mental illness than middle-class people. Similar studies (Hawkes and Taylor, 1973; Myers and Roberts, 1959; Schwab, Fennell and Warhert, 1974) have found that middle-class people are more likely to be diagnosed with depression, obsessive-compulsiveness and psychologically oriented complaints, while lower-class individuals are more likely to be diagnosed with paranoid suspicions, overt anxiety, aggressive behavior and somatic complaints.

The results of the above studies should be interpreted with caution; Fitzpatrick and Gould (1970) have warned against the use of statistics without an understanding of pattern of cultural behavior and language. They concluded that the lack of cultural knowledge could lead to inappropriate diagnosis. In the case of the Puerto Rican migrant, issues such as migration, stress and culture-conflict should be considered in both the diagnostic and the treatment process.

An Attempt to Explain Underutilization

The literature on the underutilization of mental health services by minorities posits that clients' behavioral patterns differ in relation to culture and that these differences should be considered in the delivery of mental health services. This literature questions the relevance and efficacy of traditional mental health services which have been developed to serve a middle-class culture.

Pederson (1978) has asserted that traditional counseling approaches would not be effective with minority groups. He explained that individuals with different cultural backgrounds have different value perspectives. Value perspective refers to sex-role expectations, life styles and needs which vary according

to socioeconomic level. As a result of the assertion that traditional counseling is not effective when working with ethnic minorities, much attention has been dedicated to uncovering the differences that exist between minority and nonminority groups. These differences are measured against standards which have been established by white middle-class groups.

This pattern is evident in the delivery of services to the Puerto Rican migrant. When based on middle-class Anglo perspectives, services have been reported to be incompatible with the migrant's therapy expectations, cultural expectations, value system, and psychological orientations (Arredondo-Dowd, 1980; Christensen, 1977, 1975; Mizio, 1977; Rivera, 1974; Ruiz and Padilla, 1977; Sue, 1977). The literature on the Puerto Rican migrant addresses these cultural differences and the need to develop culturally relevant services. (Delgado, 1974; Mizio, 1974).

Others have proposed that underutilization of mental health services is a problem not only for Hispanics but also for lower-class minorities in general who receive proportionally fewer and inferior services than white middle-class and upper-class individuals (Abad, Ramos and Boyce, 1974; Padilla, Ruiz and Alvarez, 1975).

In order to meet the mental health needs of minorities, it has been suggested that culturally relevant modalities need to be developed (Sue and Zane, 1987) and that services provided by psychologists, psychiatrists, mental health practitioners and social workers be tailored to meet the needs of specific cultural groups.

Treatment Modalities For The Puerto Rican Migrant

What follows is a summary of emerging treatment modalities suggested in the literature for the Puerto Rican migrant.

Family Treatment Model

The family can be considered the most important and cohesive aspect of Puerto Rican culture. The cohesiveness of the Puerto Rican family is such that members will discuss their problems first with family before seeking advice from outside sources (Christensen, 1977). According to Ahearn (1979), Puerto Ricans, when faced with severe stress or emotional crisis, will first turn to the family for assistance. Only after natural support systems within the culture have been exhausted will the Puerto Rican migrant use the mental health system.

The importance of the family in Puerto Rican culture is seen in the prolonged contact between the mother and adult children. It is not uncommon for young adults to live at home with their parents into their twenties. Family dependence is encouraged for the maintenance of cohesiveness and survival. The close-knit aspects of the Puerto Rican family have often been misinterpreted as a dysfunction. In view of the stress associated with the migratory process, family closeness and cohesiveness serve as a deterrent to family disruption and dispersal. (Canino and Canino, 1980).

The family treatment model suggests that the entire family enter treatment as a unit. This modality uses the strength of family cohesiveness as an avenue for support and problem-solving (Christensen, 1977; Canino and Canino, 1980).

Spiritism as a Treatment Aid for Migrants

Much emphasis has been placed on spiritism as a tool in helping the Puerto Rican deal with the stress associated with migration. There is vast documentation which supports the therapeutic value of spiritism in helping the migrant with problems that arise as a result of encountering and adjusting to a new culture (Crapanzano and Garrison, 1977; Delgado, 1977; Garrison, 1977, 1978; Koss, 1970; Lubchansky, Egri and Stokes, 1970; Rogler and Hollingshead, 1960, 1961; Ruiz, 1976, 1979). Mental health workers who deliver services to the Puerto Rican

migrant should be aware of the acceptability spiritism enjoys in the culture.

Spiritism is the belief that the material world is controlled by an invisible world of spirits. It is believed that spirits affect all human behavior and that no one can escape them. Spirits make themselves known to the visible world by communicating through specific individuals referred to as "Dotados" (gifted) (Kardec, 1983). These people possess special "Facultades" (faculties) which allow them to communicate with spirits and relate messages to others. "Facultades" are not found in all people; therefore, individuals who have them are considered exceptional (Garrison, 1977).

Spiritism for the Puerto Rican migrant is a form of healing where one can get help for emotional problems without the stigma of being crazy that is commonly attached to people who visit psychiatrists or mental health centers (Rogler and Hollingshead, 1960, 1961). Delgado (1977) stated that for the Puerto Rican migrant, spiritism gives an acceptable explanation of personal difficulties and offers clients concrete, action-oriented treatment. Therefore, when faced with the choice between a spiritist medium and a mental health practitioner, some migrants will choose the medium.

The model proposed by Delgado (1977) familiarizes service providers who treat the migrant, with spiritism and other available networks of support in the culture. For example, Delgado encourages therapists to familiarize themselves with "Botanicas" (places in the community where one can buy herbs with healing properties and can also consult with mediums) and to dialogue with mediums for the purpose of learning about spiritism.

Lubchansky, Egri and Stokes (1970), in studying faith healing in the Puerto Rican community, found that faith healers play a very important role in the community. Their research states that mental health professionals have ignored the importance of faith healers in the Puerto

Rican culture. This study suggests that mental health professionals work jointly with faith healers in the community and utilize them as consultants in the treatment and assessment of clients. This suggestion is also supported by Delgado (1977).

An important feature brought out by Ruiz (1976) is the commonality of language and culture between the client and the medium, which makes the spiritist setting attractive to the Puerto Rican migrant. The model suggested by Ruiz posits a reciprocal relationship in both consultation and training between the mental health center and the spiritist center.

Perhaps the most commonly used example in the literature on the effectiveness of spiritism as a therapeutic tool is the treatment of "Ataques" or "The Puerto Rican Syndrome." Observed and recorded symptoms of "Ataques" include the following: an uncontrollable outburst of anger and hostility, uncommunicativeness, pseudoepileptic movements of arms and legs, property destruction and attacks on others, salivation and hyperventilation, as well as partial loss of memory and orientation to reality (Berle, 1958; Rubio, Urdaneta and Doyle, 1955). Although these symptoms have been recorded from actual observations of the syndrome, there is no agreement among professionals on symptomatology, diagnosis or treatment.

Interpretations of the etiology of the "Ataque" syndrome include the following: hysterical expressions of unresolved anger (Mehlman, 1961; Trautman, 1961); a reaction to stress due to the inability to deal with environmental changes (Garrison, 1977); an internal mechanism used to prevent psychotic breaks and a discharge of pent-up feelings of distance from mother which have been repressed (Fernandez-Marina, 1961); an outburst reaction to the strict expectation in the culture that anger should be repressed to give the appearance of docility (Rothenberg, 1964), and an acceptable and direct displacement of anger which serves as an avenue for secondary gains, but is primarily directed at the repressive social and economic conditions which exist in the

individual's environment (De La Cancela and Zavala-Martinez, 1983). The incidence of "Ataques" is documented to be highest in members of the lower socioeconomic class and women (Berle, 1958; Garrison, 1977; Rubio et al., 1955).

In the case of "Ataques," spiritism deals with their manifestations as one level of spirit possession. Individuals with the syndrome are viewed by spiritists as exceptional since their behavior denotes that spirits are communicating to the material world through them (Garrison, 1977).

The supportive aspects of spiritism were presented in another study by Garrison (1978). In studying migrant schizophrenic women, Garrison found that even while in treatment at mental health centers, participation in natural systems existing in the community was maintained. The support systems used most by the women included family members, religious organizations and spiritist settings. Garrison (1977) suggested that "Support network therapy" be incorporated in the treatment of the Puerto Rican migrant. She went on to explain that this combined approach in the treatment of the migrant can help overcome professional, as well as institutional constraints which at times keep clients from receiving appropriate services.

Model for Addressing the Social Context of the Puerto Rican Migrant

A social approach to therapy has emerged out of the concern that traditionally oriented therapies are not effective in dealing with the problems of ethnic minorities (De La Cancela, & Zavala-Martinez, 1983; De La Cancela, 1985a, 1985b). This approach is based on the notion that systems or environments have built-in constraints which impact on individuals and result in numerous problems. This model's central premise is that therapy should deal with the individual's environment. In the case of minorities, the model posits that therapies oriented to the individual rather than to the environment can very easily become self-defeating. Individual approaches often

overlook problems which develop out of unemployment and poverty; therefore, from this perspective, lack of progress is then a reflection of the victim and not of the system or environment (Gil and Gil, 1985).

The condition of poverty has been associated with negative self-image and generalized feelings of demoralization. A therapeutic situation which does not address the problems arising from the individual's social context might very well reinforce negative feelings in the client (Montijo, 1985). Assuming that problems stem from the individual and not from the social context accepts the environment as fundamentally sound and overlooks the potentially detrimental effects that it could produce in the individual (Galper, 1978).

A conceptual framework which interprets problems as a direct result of an individual's behavior and not of the system or environment blames individuals for their own problems. The widely used concept of the "Culture of poverty" is an example of how individuals are stigmatized as members of a deficient culture which engenders poverty (Ryan, 1976). The lack of social progress typical of the so-called culture of poverty leads to many interpretations which become misconceptions and tend to stereotype individuals in these groups (Montijo, 1985; Ruiz, 1979).

An aspect addressed by this model has to do with the role that institutional barriers play in maintaining stereotypes and misconceptions about the Puerto Rican migrant and other minorities. The presence of institutional barriers which keep the Puerto Rican migrant from getting appropriate services was discussed initially by Delgado (1974) and later by De La Cancela (1978, 1985a, 1985b, 1986; De La Cancela et al., 1986b). Institutional barriers are present in the field of education, as well as in the delivery of services to minorities. De La Cancela (1978) wrote about his experience of being a minority student in a clinical psychology program, describing the lack of course offerings in the delivery of services to minority clients despite the fact that the educational institution made a point of recruiting minority

students who were to deliver services to minority clients.

An example of institutional barriers can be seen in an observational study conducted by Wojcick-Sharff in 1981. The aim of this study was to investigate the degree of enterprise of the ghetto family. The method employed in the study involved participant observation of about 36 families, consisting of 133 individuals. The study was conducted in New York's Lower East Side, an area made up primarily of Puerto Ricans. In describing the physical environment, the author pointed out that more than half of the buildings in the area studied were abandoned or burned out, and that the area had the highest proportion of families with the lowest income in the city and an unemployment rate of 60 percent. The study found that, contrary to the general notion that poverty causes unwillingness to work, lack of skills, ignorance and apathy about contraceptives -- hence large families which engender more poverty-causing qualities through the so-called culture of poverty -- poor people are hardworking and quickly develop the requisite skills when reasonable work is available. Further, it was found that large families do not keep the poor in poverty, but rather serve as a mechanism for survival.

The static and deprived position of Hispanics was addressed by De La Cancela and Zavala-Martinez (1983). Their work suggested that prevailing attitudes toward Hispanics serve to preserve their position in this country as poor and unmotivated. The authors also questioned the present culturalist movement which attempts to address the condition of Hispanics and other minority groups without incorporating them into the social order. (De La Cancela and Zavala-Martinez, 1983).

Unlike traditional psychotherapeutic approaches in which the aim is to make the client aware of unconscious processes, social-oriented therapy helps the client question the oppressive features of the social context. Psychotherapy from a social approach integrates the following principles: (1) confronting social systems and environments that are oppressive and which lead to crime, sexual deviance, depression, and alienation, (2) an

examination of labeling (pathology) and treatment which views people as deviant and unworkable, (3) a democratic sharing of expertise between professionals and clients and decreased emphasis on the professional client-relationship, (4) an examination of beliefs that are commonly used in the therapeutic process, e.g., open communication and acceptance, and (5) encouragement of clients to give feedback on the therapeutic process (De La Cancela, 1985a).

The Acculturation Model

The acculturation model was developed by Inclan (1980, 1983, 1985) to aid Puerto Rican migrants with the problems that arise when they encounter a new culture. The process of adjusting to this new culture can cause numerous mental health problems (Torres-Matrullo, 1976).

The values encountered by migrants upon arriving in the U.S. are quite different from their own. For example, Anglo middle-class values are centered around financial gain and expenditure with a sense of accomplishment derived from what one becomes; in Puerto Rican culture, a sense of accomplishment derives from belonging rather than from doing. For the Puerto Rican the feeling of personal achievement is tied to respect for family traditions; therefore, the assimilation of other cultural values has implications for family cohesiveness (Inclan, 1985).

According to this model, therapy should attempt to persuade the client to examine the values presented by the new culture and look for strategic ways of helping the acculturation process. A culturally specific tool developed by Inclan in 1980 is the Puerto Rican Acculturation Measure. This instrument attempts to measure acculturation in terms of the acquired knowledge of culturally specific items common to both U. S. and Puerto Rican culture. Items relevant to the U. S. culture include: (item 12) which is the largest river in the U. S.? and (item 48) Give the name of a Christmas carol. Items related to the Puerto Rican culture include: (item 39) Who was Tito Rodriguez? and (item 55) What is Lares famous for?

The acculturation model emphasizes the need for service providers to become familiar with the values of the Puerto Rican culture. This model also points out that within the Puerto Rican culture values may vary in relation to social class and generational differences. Finally, this model urges mental health service providers to become more sensitive to the needs of migrants and to interpret their problems in relation to the process of acculturation (Inclan, 1985).

Model to Address Sex-Role Conflict in Women Resulting from the Process of Acculturation

The process of migration and acculturation has been linked to psychological stress (Inclan, 1985). Increased psychopathology in Puerto Rican women migrants has been linked to sex-role expectations (Torres-Matrullo, 1976).

Sex Roles in the Puerto Rican culture are clearly defined. For example, men make most of the decisions around family issues, but household tasks and child rearing are done primarily by women (Acosta-Belen, 1979).

Upon coming to the U. S., the involvement of women in the work force tends to increase because of financial need and the availability of jobs in the garment industry. For women who enter the work force, having to keep the cultural expectations of their traditional roles is a factor of stress (Acosta-Belen, 1979; Christensen, 1975). Women entering the work force can no longer live up to the tradition of staying home to take care of the children. Some have even gone as far as to interpret women's involvement in the work force as indicative of a loss of authority by their husbands (McGoldrick, Pearce and Giordano, 1982).

Following the interpretations of Torres-Matrullo (1976) that psychopathology in migrant Puerto Rican women is linked to sex-role expectations, Soto (1983) studied the impact of sex-role traditionalism in Puerto Rican women living in the U. S. The study by Soto

revealed that in migrant Puerto Rican women, lower assertiveness is associated with sex-role traditionalism. Soto's study suggested that assertiveness training may lead to positive mental health growth in Puerto Rican migrant women.

In view of the models and the specific suggestions presented for treatment it is evident that any conceptual framework used in developing programs for the migrant must incorporate culturally syntonic avenues to make services attractive to the migrant.

Relevance of the Present Study to the Literature

The literature devoted to the mental health treatment of the Puerto Rican migrant centers primarily on two major areas. First, it addresses the culturally sensitive. Second, it suggests that services for migrants need to be relevant to their needs. This literature has provided suggestions for treatment which require further analysis on how they might actually work in practice.

This study was developed to observe and describe the application of treatment designed specifically for the Puerto Rican migrant. The program's location and utilization rate were major determinants in its selection.

The study took place in a large city of the United States. The center was strategically placed in an area with a large population of Puerto Rican migrants. This program emerged in 1985 and was specifically developed to provide mental health services to Hispanic migrants living in the area. The center serves an average of 450 clients per month. According to the City Office of Mental Health 1986 Final Evaluation Report, about 18 percent of clients who attend the center are referred by the school system, 15 percent by other human service agencies and 14 percent arrive by self-referral. Forty-nine percent of clients served at the center are Puerto Rican; 62 percent are female; 53 percent have not completed high school, and 63 percent have had no prior contact with mental health care.

This study is a systematic effort to observe, define and describe the methods and techniques of treatment implemented at this center. It is an attempt to describe the cultural and interactional patterns of people who deliver services there. The research method for data collection and data analysis is ethnographic, an approach suited to the description of cultural patterns. This qualitative approach may help define critical variables for future study of such programs, given that this is the first documented attempt to systematically observe and describe what is done at a treatment program specifically developed to serve the migrant.

CHAPTER III

DESCRIPTION OF RESEARCH METHODS

This is an on-site ethnographic study of a mental health center which was developed to serve Puerto Rican and other Hispanic migrants. Data were collected within the span of two months. A total of five full weeks were spent on the actual site, excluding time spent planning for the study. Data were gathered through observation of staff activities within the center and through informant interviews. This was done in two intervals to allow time for the recursive process of data analysis.

The first interval of data collection took place during a three-week period in 1988. During this period data gathering centered on informal interviews with staff; observing and recording the physical structure of the center, staff structure and schedules; general interactional patterns within the center, including movement in the waiting area; procedures for scheduling sessions and staff, and staff interaction with other staff and clients.

The first period of data collection was followed by two weeks spent in analyzing the data at hand. A total of 61 themes or recurring patterns emerged from the initial data. For example, two-thirds of the observations indicated that after the arrival of the staff at the center, the janitor changed the radio station from a Spanish-language to an English language program.

The consistently documented pattern of the janitor's behavior was defined as one theme. Themes were then arranged into coded categories that were either data-derived or theory-based.

The themes which emerged from the data analysis at the center were arranged under the following codes: culture, treatment, treatment staff, political topics, roles of treatment staff, clients, staff hierarchy, physical description of the center, student interns, religious topics and structure vs. nonstructure. By analyzing the data within this framework, it became evident that there was

valuable information to be collected about the work of the therapists at the center. Therefore, a second period of data collection was scheduled, focusing on therapists.

During the interviews with therapists it was evident that they thought that their work with clients at the center was unique because of their knowledge of Hispanic culture. Later, during the final analysis of data, the beliefs presented by the therapists in the interviews about delivery of services were compared to their behavior as observed during the actual and direct delivery of services to clients. The second interval of data collection, then, centered around formal observations and interviews regarding what was done by the therapist in the actual delivery of services to clients.

The second period of data collection also afforded Jose Reyes, the primary author an intimate view of the center's catchment area. Jose lived with a migrant couple about three blocks south of the center. He was thus able to acquire first-hand knowledge of the neighboring community. Poverty was pervasive and drug deals on the street were a daily occurrence. He learned which streets in the community one should not walk down and which were safe. This came by word of mouth through the staff at the center. He also learned where to get the best Puerto Rican food and the best "Morcillas" (blood pudding). Living in the community provided a higher level of participant or emic understanding of the migrant and the culture which surrounds the center.

Observation of Staff Activities Within the Center

Direct observation and documentation methods were used throughout the study to provide data on the workings of the center. All data observed were recorded on a field note sheet. This method of recording provided the opportunity to gather factual information about the observation. For example, on a designated day from 7:20 a.m. to 9:40 a.m. the focus of the observation was to document the staff arrival times. This same method of recording was used in the observation of staff meetings, therapy sessions and interviews with informants. This

method of collection provided the following information for each given observation: focus of the observation, data-based index by which the field-note data could be summarized and coding of data collected in the observation.

For final analysis, all indices were further classified. Though labor intensive, this process of data analysis brought together all data-based categories and facilitated a final structure for the data narrative.

Research Process

Data gathering began four months prior to the collection of data at the site. The first contact with the center and negotiation for entry into the setting was followed by numerous phone calls and letters explaining the intent and rationale of the study. Two months into negotiations the site was visited to further discuss the possibility of conducting the study. Following the visit at the center, the program director requested that a research proposal be submitted for official approval. The proposal was reviewed by the governing body of the center, the New York City Health and Hospitals Corporation. Official approval to conduct research at the center was received three weeks prior to on-site collection. A total period adding up to 36 full days was spent in the field collecting data about the center and the community in which it is located.

The period of data gathering at the center produced 139 pages of field notes. Analysis of these field notes produced a total of 61 themes which were arranged into 13 codes. The coding was developed out of the general category of themes. For example, included under the code of Culture are the following themes: cultural sex roles, teaching of culture, cultural beliefs, cultural treatment tool and cultural exploration. Other codes were: Treatment, Staff, Politics, Roles, Clients, Staff Hierarchy, Physical Mapping and Interns. Analysis of the data indicated that 29 themes were arranged under three codes. The data indicated 13 themes under the code of Treatment and six themes under the code of Staff.

Further, the field notes contained data on 12 group therapy sessions which were observed during the six weeks in the field. The data on the group therapy sessions were obtained through a one-way mirror. The two women's groups which are conducted weekly at the center (Depressed Women's Group and Mid-Life Crisis Group) were documented in the data. No men's group is held at the center.

The data also included six informant interviews with staff. Each interview lasted approximately an hour and a half. Four of these interviews were conducted with formal staff and two with informal staff. Each of the interviews was conducted in the family therapy room. Prior to the beginning of the interviews, each person interviewed was assured that all information provided would remain confidential and that no identifying data would be released. Further, the soundproofing of the room offered the persons interviewed a confidential setting to answer questions in an open and forthright manner. The assurance of confidentiality enhanced the likelihood of receiving candid, spontaneous responses.

The 136 pages of field notes represented a total of 55 data-gathering observations. All field-note data were translated during the actual observation and recorded in English. The process of translating the data into English was not tedious given the researcher's fluency in both languages.

The data were organized according to the codes. The broadest ranging themes emerged under the code of Culture. The culture of the center including communication patterns and use of food provides the data base for the findings in Chapter IV. This section also presents data coded under "Staff." The staff data describe themes which emerged from the interplay between the formal staff (staff hired for direct service) and the informal staff (all other employees).

Findings on actual treatment are examined in Chapter V. This chapter presents narratives of therapy sessions as delivered by therapists according to the themes

which consistently emerged in the data. Chapter VI presents ideological data derived from formal interviews with therapists regarding their work with migrants.

CHAPTER IV

THE CENTER: SOCIAL ORGANIZATION AND CULTURAL PATTERNS

This chapter describes the social organization and cultural patterns of the center. Specifically, the following themes are examined: the community, the center, communication patterns, use of food, the concept of time, staff structure, informal staff, formal staff and treatment structure.

The Community

The center is located in a changing neighborhood composed of poor, primarily Hispanic migrants. A large part of the community consists of low-income housing projects provided by the city. Recently, a number of abandoned buildings have been sold to private corporations for renovation. This seems to foreshadow the driving out of the traditional community members as more affluent residents move into the area.

There are numerous abandoned buildings on the street where the center is located. On the corner nearest the center is a parking lot surrounded by barbed wire reminiscent of that used in jail yards to keep prisoners from escaping. Across from the parking lot is a large Puerto Rican flag which hangs outside the window of a first-floor apartment. Also visible to the person who walks on the street are a number of plants and roots placed on a window ledge with what appears to be the statue of a saint.

The Center

The center is a large square building without windows. The main door leads to a small partitioned room on the left side of which sits a guard who checks the identification of strangers who enter the center. Once identification has been cleared, the visitor passes into the reception or waiting area.

The waiting area can accommodate about 20 clients. Adjacent to the waiting area is a separate room where children can play in while they wait for their parents. This small room is equipped with toys, crayons and wooden blocks.

The decor of the center is based on themes which are consistent with the population the center serves. For example, the waiting area has art posters promoting Hispanic culture and a display of maps showing the countries of Central America. All pictures at the center convey a cultural message about the clients served or the community which surrounds the center. For example, one post depicts a sign with the name of the major street in the community; the sign is held by hands of all races and the legend reads "Uphold the Community." One of the therapy rooms has a poster announcing a World Conference of Solidarity. It is written in four languages -- English, Spanish, French and Russian.

The literature in the waiting area is in both Spanish and English. A rack displays magazines and literature on immigration and minimum wage laws and upcoming events in the community in regard to housing and community development. There are also copies of a community magazine called "The Quality of Life in the Community" ("La calidad de vida en la comunidad"). This is a bilingual (English and Spanish) publication which comes out every two months and deals with business, economic, political and developmental issues facing the community.

The literature in the children's area consists of storybooks in English only. This may indicate that the children who come to the center are more literate in English than in Spanish.

The center's hours are as follows: Monday and Thursday, from 9:00 a.m. to 8:30 p.m., and Tuesday, Wednesday and Friday, from 9:00 a.m. to 5:00 p.m. The janitorial staff's work schedule starts at 7:00 a.m. and ends at 3:00 p.m., Monday through Friday. My observations at the center began at 7:00 a.m. and ended at 5:00 p.m.

daily.

Communication Patterns

Data on communication patterns emerged from observations of staff interactions, delivery of treatment and staff meetings. Themes on communication patterns provided information about when and in what context English or Spanish is used.

All staff at the center are bilingual, since proficiency in both English and Spanish is a requirement for employment. Exceptions to this rule are made for student interns who are training in family therapy at the center. These students who are not proficient in Spanish, work mostly with second or third generation migrants who speak English as their native tongue.

About 43 percent of the clients who attend the center do not speak English. Therapy sessions are held in the language preferred by the client. At times, the client switches language to express complex concepts which cannot be adequately expressed in the other language. For example, during the observation of a marital counseling session in which English was spoken predominantly, the wife began to use Spanish to explain to the therapist the way she felt about her husband not treating her like "Su mujer" (his woman). In the context of the session, "Su mujer" had connotations of protectiveness.

English is most commonly used by second and third generation migrants. Of the 12 group-therapy sessions for women observed, all were conducted in Spanish. Participants in all these groups were first-generation Hispanic women, most of whom were Puerto Rican.

The use of language also varied according to context and situation. Staff meetings were held in Spanish and English. The same dynamic interchange of language noted in the observation of client sessions was also observed in staff meetings. For example, in a case presentation made in English, the presenter at times would switch to Spanish to impart the correct cultural meaning.

In all case presentations observed where student interns not proficient in Spanish were present, the meetings were held in English. All students interning at the center were first or second-generation Hispanics and all were proficient in English. At one meeting, where student interns were not present, a case was presented entirely in Spanish. The same dynamic interchange of language noted in the observation of client sessions was also observed in staff meetings.

One administrative meeting was observed. The director of the center met with the administrative staff of the hospital which oversees the work of the center. This meeting was held in English, since the administrative staff present at the meeting was not proficient in Spanish.

Noted was an increase in nonverbal expression while using Spanish. The nonverbal expressions most consistently documented were hand movements and, to a lesser extent, touching or close proximity to the listener.

Interchange between language (code-switching) was a common occurrence during the working hours at the center. Language interchange (code switching) was not noted in the early hours at the center (7:00 a.m. to 9:00 a.m.). The staff who arrived in the early hours were the janitorial staff, first-generation Puerto Ricans, and the guard, who was third-generation Puerto Rican. Spanish was spoken at all times in the morning prior to the arrival of the formal staff.

In sum, the center provides clients with the opportunity to speak both languages, as well as the choice of which language to speak.

Use of Food

Food was present at all staff meetings observed at the center. At the first staff meeting observed, coffee, bagels and oranges were brought in by a therapist. All food at the center was provided by either staff or clients.

Food was also present in the therapy groups which I observed, as for example, in those meetings of the Mid-Life Crisis Group. This group met once a week and was observed during the entire research study. In all group therapy meetings the women brought coffee and buttered bread or pastries. Before or during each meeting, the female janitor prepared a fresh pot of coffee and heated up the bread or pastries in a microwave oven located in the staff lounge. After heating up the food, the female janitor brought it into the therapy room while the meeting was taking place. The therapist who conducted the Mid-Life Crisis group explained that food served to create a bond among members, as well as a relaxing atmosphere analogous to being at a "Plaza de recreo" (public square), where people in Hispanic countries gather daily to discuss politics and other topics of community concern. Food also provided a transition into expected agendas. For example, when there was no food present, the group discussion would center on greetings and informal conversations about community events. Once the female janitor entered the room with food, the group would shift to conversations about themselves.

Food was also part of the group process in the Depressed Women's Group. Food was present in four out of six group sessions observed. In addition, the group held two pot-luck meals at the center prior to commencing their sessions. Again, once food was introduced the group interaction became more personal and therapy-oriented. Food was also present at the two administrative meetings which were observed. The introduction of food marked the start of the business agenda.

The introduction of food began in the morning before the arrival of the therapy staff. Upon arrival at the center at 7:00 a.m., the janitorial staff had coffee, buttered bread and pastries. Routinely, my conversations with them were held in the morning while eating and drinking coffee. Food was such a large part of sharing information that Jose Reyes learned to stop in the morning before entering the center to buy bread and bagels for the janitors.

Concept of Time

Opening and closing times at the center were kept to the minute, due to a back-up security system which was activated at the scheduled opening and closing times. The janitors and the guard arrived promptly at 7:00 a.m. The janitors left the center at 3:00 p.m. while the guard remained until closing at 5:00 p.m. Therapists began arriving at the center from 9:00 to 9:45 a.m., on an average of 10 to 20 minutes late.

Therapy sessions were generally an hour in duration. Clients arrived on time for their appointments and therapists were usually punctual. However, on two occasions in three weeks, therapists arrived late for a 9:00 a.m. therapy session.

Staff Structure

The staff is composed of administrative, clerical, janitorial, security and treatment personnel. The administrative staff consists of a full-time program director and an administrative assistant. The clerical staff includes a full-time director's secretary and two other secretaries who also serve as receptionists. There are two full-time janitors. The therapy staff is composed of four full-time therapists and two part-time psychiatrists. Part of the therapy team includes the Family Training component which is headed by a part-time therapist and a part-time psychiatrist. For security reasons the center has a guard who monitors arrivals and departures during office hours. The staff also includes six graduate students in social work and psychology who are interning as part of their course requirements. All hired staff at the center are bilingual. All treatment staff are first-generation migrants, except for a part-time psychiatrist who is a second-generation Cuban. During the observations for this study there were two vacant positions for full-time therapists.

The Informal Staff

There are two janitors, male and female, who were both born in Puerto Rico, with the male appearing to be in his late fifties and the female in her late forties. Both have lived in the United States for more than 30 years. The guard, who appears to be in his late thirties, is a third-generation Puerto Rican who speaks broken Spanish.

Upon opening the center at 7:00 a.m., the first task of the informal staff is to make a fresh pot of coffee. Then the two janitors sit in the staff lounge to read the Spanish language newspaper and listen to the Spanish language news station. This provides them with topics of conversation, such as the differences between life in the United States and in Puerto Rico. Often the janitors would sit and reminisce about the past when they lived in Puerto Rico, always emphasizing that things are not the way they used to be: "Las cosas no son como eran antes." These discussions also reflected sex-role expectations and how these expectations have been maintained in the face of the changes and struggles which they encountered after migration.

The female janitor often talked about the difficulty of putting her children through school with very limited resources. Twice a widow, she stated with pride that she managed to raise her children without going on welfare. After her second husband died, she did not think it was a good idea to bring a man into the house with two "Senoritas" (young unmarried women) present. She stated, "My daughters were pretty, so why should I bring a man to the house to give me trouble? In fact, I did not date until my daughters were out of the house and married."

The male janitor often reflected on his upbringing in Puerto Rico and how his parents taught him values that are not taught to children today. He would often use topics such as education and teenage pregnancy to illustrate his point. For example, one morning after listening to the news and hearing about the national crisis of the U.S. educational system, he said that the reason educational quality was declining was because children

and not teachers are in charge of the schools. He began to reminisce about his early days in school in Puerto Rico and about how much power was given to the teacher. He stated, "When I was going to school I remember my teacher would punish me for not doing my homework, and if she needed to spank me she would, and my father would support her all the way. Nowadays, if a teacher hits a child, the teacher and the school get sued."

Once, on the second day of data collection, Jose Reyes arrived at the center early and observed that the female janitor answered an incoming telephone call and oriented the person to call later. There were at least two calls every morning from people who wanted information about their problems. Calls started sometimes as early as 7:00 a.m. and would end before 9:00 a.m., the time the center opened to the public. Some calls were of a personal nature and related to interest in folk healing traditions.

For example, one morning the female janitor answered the phone and said, "Look, all you have to do is light a white candle, but you have to make sure it's white or else it won't work. Make sure you get a big candle so that it will burn longer than a half hour. Then what you do is put it next to your bed when you are at home. You will see, my advice will work. I will call you later." She told Jose Reyes that the person who had called early that morning was a friend who thought that her husband was having an affair and wanted her advice about what to do to stop about her husband's infidelity.

During informant interviews, questions were asked of other staff about the role of the female janitor at the center, but no one acknowledged her knowledge of folk healing. The program director and a therapist, however, did acknowledge the role of the female janitor as a special one. Once the program director asked Jose, "What are you doing here so early in the morning when there are no staff or clients?" Jose used the opportunity to ask about the janitorial staff and their role at the center. He began to talk about the female janitor, stating that she had been at the center since it opened. He said, "Every New Year's Day, she lights candles. She has spread incense and

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perfumes around the center since it opened." He asked the director what this meant. He answered, "She is working out of her own beliefs and she does that to keep the center free of interference." He asked what was meant by "Interference" and he replied, "Spiritual interference." When the director was asked to elaborate on this, the conversation shifted to another topic. The same thing happened with a therapist who acknowledged the spirit knowledge of the female janitor; however, when further elaboration was requested, she also changed the topic of conversation.

The theme of spiritism was also documented during the physical mapping of the janitor's locker room. In this room, the female janitor changes her clothes and keeps her personal belongings. On one wall across from the locker is a large picture of Jesus Christ on the cross and on another wall a picture of a female saint.

At 9:00 a.m. or the time the first full-time staff member arrives at the center, the male janitor lowers the volume of the radio and switches the station to an English language one.

The Formal Staff

Upon the arrival of the formal staff in the morning, the ritual was to congregate in the staff lounge to talk in Spanish about the news in the United States and abroad. Often the talk centered on politics and new developments in the city and the community. This period in the morning also became a time for the staff to attempt to get Jose Reyes'perceptions of the center and for them to offer information that could be helpful in his understanding of its workings.

The morning gathering of formal staff included administrative staff, treatment staff and student interns. Food was always present: freshly made coffee, buttered bread, pastries, ham and cheese sandwiches and bagels.

Treatment Structure

During formal office hours, both the informal and formal staff played an active role in the provision of services to clients. The female janitor, as we have seen, played a informational role that went beyond her janitorial tasks. She was also observed to be friendly and supportive of clients while at the center. One day while Jose Reyes was sitting in the staff lounge, a conversation developed between a therapist and the female janitor on the reasons why a particular client was no longer attending counseling sessions. On another occasion, a therapist consulted the female janitor about a particular spirit medium who had died and had worked with individuals in the community. In this instance, the female janitor provided the therapist with information about the medium which seemed important in understanding one of the client's problems. The female janitor also provided information on community events and on the progress of past clients of the center. She occasionally served as a receptionist, assisted the clients as they arrived at the center and greeted all she came in contact with. She also played a role in the Mid-Life Crisis therapy group. She made coffee and heated up pastries and brought them to the group. During her entrance and exit, the flow and content of the group's discussion remained constant and uninterrupted. After the introduction of food, the group discussion would increase.

Acknowledgement of the female janitor's supportive role in treatment was occasionally a topic discussed either formally or informally among staff during the time the research study was conducted. The decision not to ask further questions about this dynamic centered on the concern for actual documentation without interruption of the natural workings of the staff. The next chapter presents transcriptions of therapy sessions which were observed and documented at the center.

CHAPTER V

THE DELIVERY OF THERAPY

The data in this chapter are based on the observation of actual therapy sessions at the center. The four cases that follow illustrate themes on acculturation, the presentation of symptoms in a culturally specific vernacular (spiritism) and clients' need for a support network.

Case #1: Migration

The first case presents a married couple who migrated from Puerto Rico eight years ago because the husband could not find stable employment there. Since migrating to the United States, the couple has experienced a breakdown in communication and intimacy. Although the husband is currently working, he is unhappy with his job because he cannot provide financially for his family at the level he wishes. The couple have two children and have been married for 16 years. They have been attending therapy sessions at the center for over two years.

One of the themes which emerged in this session related to sex-role orientation. The husband is attempting to maintain a position of authority and the role of protector, as is traditional in Hispanic culture. The therapist worked with the couple to achieve closeness while considering the cultural themes which surfaced. The presenting problem, as described by the therapist, centers around the husband's slow adjustment to a new culture and new value orientation. The therapist also stated that the husband has recently had a hard time accepting his wife's congenital blindness. Prior to migrating to this country, the wife worked as a social worker but left her job to come to the United States. The therapy session was conducted in Spanish.

This particular session attempted to deal with the husband's physical aggression, which would arise whenever the couple began dealing with intimacy. The

therapist directed herself to the husband and attempted to get him to understand that it is very hard for men to express feelings. The therapist told him that his inability to express feelings is often related to his feelings about his manhood, but in the context of his relationship with his wife this behavior does not help communication.

The therapist immediately connected at a cultural level with the husband by acknowledging that the nonexpression of feelings is a cultural trait. The therapist also explained that this trait is not necessarily bad but, in the context of the relationship, expression of feelings would help him to communicate better with his wife. The therapist then explained to the husband that probably these patterns of behavior are related to living with an authoritative father who had executed his parental role "As if he were Jesus Christ."

The particular topic under discussion was a situation in which the husband had become upset because his wife would not bring him a cup of coffee when he asked for it. The therapist attempted to get the couple to relate at a feeling level. Further, the therapist tried to get the husband to understand what he really needed when he asked his wife for a cup of coffee and how it feels not to be able to get what he needs. The therapist then explored his feelings, discovered that the husband was hurt because the wife had given him her wedding band two days ago because they were not communicating.

The therapist suggested to the husband that his anger about the coffee was his punishment of his wife because he was not able to talk about his feelings. At this point the husband began to cry. The therapist reinforced his behavior, saying that it is better to express feelings than to keep them inside. The wife then began crying also. The husband handed her a handkerchief.

The therapist, resorting to a maternal role, talked to both of them saying that if they wanted to stay married they had to act like adults and not children. The therapist advised the wife not to act like a "Malcriada" (someone with bad manners).

This case presents a therapeutic orientation which acknowledges cultural mores. The therapist used her knowledge of the culture to reframe, interpret and advise at a level which was familiar to the clients. For example, the maternal role is highly ingrained and respected in Hispanic culture. The therapist, in assuming a maternal role, strengthened the impact of her statements on the client.

Case #2: The Spiritual Element

The second case presents a theme which consistently emerged at the center: concerns with the spiritual element. This case also illustrates a therapeutic environment that provides clients with the opportunity to share common experiences in a way which is culturally accepted.

The following illustration of the spiritual element is taken from a meeting of the mid-life crisis group. According to the therapist who led the group, most members of the group had undergone drastic family changes such as a death, departure of children from home, divorce or separation. The group meets every Wednesday for an hour and a half (10:30 a.m. to 12:00 p.m.). Members of the group include first-generation Hispanic migrant women, most of them from Puerto Rico, who had come to this country from two to twenty years ago. The group has eight regular members. The therapist indicated that absenteeism and turnover are rare, and only occur in extreme circumstances such as death and severe illness. The therapist stated that when the group knows a member is not able to attend because of illness, the group meets at that person's house.

The session opened with a member asking if anyone had ever experienced a "Celaje" or apparition. Another member stated that at times she sees things that other people do not see and that this makes her very afraid. Two other members then described situations in which they had seen things others did not see.

The therapist encouraged the members to talk about such apparitions. One member said that it is common in her family to see "Celajes." She went on to say that she had seen her father, mother and one uncle after their deaths. This had happened several times in her kitchen when she was by herself. She reported that now when it happens she is no longer afraid. Another member related that while she was drying her hair looking at the mirror she saw something but could not tell what it was. Often when she is at home by herself, she is very afraid.

The therapist intervened by explaining to the group members that "Celajes" happen to many persons and that often they have meanings. The type of intervention provided by the therapist had two messages. First, a message was given to the clients that apparitions are normal in the context in which they were being discussed and, second, that the verbalizations of apparitions have further meaning. This intervention confirmed to clients that what was being presented had value and meaning and fit into the cultural context of the group.

A member explained that one night she had to get out of bed on three separate occasions to turn off the light. This happened after her son, who had lived with her for years, moved to his own apartment. Another member told of a woman who lived near her house when she was a child in Puerto Rico. She said, "She worked helping around the house at my godmother's and was also a friend of my mother. One day there was an accident and the woman got hit by a truck and died. She was planning to get married that week so they buried her in her wedding gown. On the day of her funeral a man at the door would not let me enter to see her. I remember there were so many people there - you know how it is in Puerto Rico, everybody always goes to pay tribute to the dead. I remember going home and crying in the kitchen, then my mother walked in and asked me why I was crying. I told her it was because they would not let me go in to see the funeral.

The therapist then turned to the group and said, "Often in therapy when one converses about things that

have happened in the past one tends to find associations. I am sure that all of you can remember things that happened to you when you were a child, but associations makes you remember those things more often."

The therapist then turned to the client, saying, "It would be interesting to hear what your memory of not going to the funeral 'Te saca' (brings out of you). The intervention made by the therapist moved the client from one familiar frame of reference to another. By directing the client to associate feelings of the here and now to the apparitions, the therapist was attempting to get the client to connect with her feelings.

The client responded that this memory evoked "Miedo" (fear). The therapist responded, "Is it fear of the dead?" The client replied, "No," but that as a child she remembered that the town cemetery was down the street from where they lived and people would see apparitions of the dead all the time.

Another member of the group stated that when she was a child a women would appear to her at home. One woman said that apparitions of the dead happen all the time, especially in Puerto Rico. She explained, "I remember that whenever I was bad my grandmother used to tell me, 'When I die I am going to make you pay.' Soon after she died I remember being in the kitchen doing the dishes and suddenly I heard my grandmother calling me, but when I turned around there was no one there. I was so afraid. Then it happened again and although I could not see her I would speak to her. That is why I am not afraid of the dead."

A group member said that the same thing happened to her after her mother died in Puerto Rico. She said, "I remember that when they found out that my mother was going to die, my father would not allow anyone in the house to pray for her. He would not even allow it the night that she died. But on the night she was buried while I was in bed with my door open, my mother suddenly appeared in the hallway saying repeatedly, 'Oh my daughter, oh my God, they changed my pathway to be

with the Devil.' Then I remembered that my father had not allowed anyone to pray for her. These apparitions went on for months. It got to the point that I could not stand the house with all the noises she would make at night. So I consulted a lady who knew a lot about things like that and told her about the noises and hearing my mother at night. I even told her how I felt at night and she told me that she would do the nine rosaries so that her spirit would leave in peace. The lady with whom I consulted came that same night and prayed the nine rosaries and by the last rosary you could feel the house trembling. You could feel the spirit leaving the house. That is why I believe that the dead have to be prayed for, that is their bread."

Another client remembered that as a child she was very scared at night after her grandmother's unexpected death. She stated that she remembers noises that the spirit of her grandmother would make outside the house in her attempts to get inside.

A client told the group that although some people say that the dead do not appear, they do. The group member said, "The person does not appear but their spirit after death does, believe me." The same member went on to explain, "The case of my daughter's mother-in-law can attest to that. My daughter took care of her mother-in-law for five years because she was terminally ill. Instead of being grateful to my daughter her mother-in-law was very nasty and brutal to her. They were both in Puerto Rico and I could not help because I was here, so I sent my daughter a ticket so that she could come here to take a break and she did. A month after my daughter arrived her mother-in-law died in Puerto Rico. The night she died my daughter started screaming and crying in her room and I went running to see what was wrong and she said, 'I saw her, I saw her'. She said that her mother-in-law had appeared to her dressed in white at the edge of the bed. I have always thought that since she treated my daughter so bad, the mother-in-law had come to ask her forgiveness. That happened more than 19 years ago and she still appears to her at times. I have told her several times, 'my dear, light her a candle.' A group member

confirmed that it is best to light a candle and that the next time she appears, her daughter should tell the spirit that all is forgiven. The group unanimously agreed that her spirit needed to be forgiven and should be granted that. Another person related that she had seen the spirit of her father, mother and uncle, and still does at times, but is not scared anymore because she has prayed for their spirits.

One woman asserted that some apparitions are different from others. She said, "Last Monday I was home and thought I saw the shadow of a man, but that happened because I saw a scary movie that night. Whenever things like that happen and I get scared, I get down on my knees and pray."

In an attempt to get the group to connect the apparitions to their present feelings, the therapist asked the group if, when they have these apparitions, there is some specific traumatic event going on. The group responded by asserting that these apparitions are very real and cause great fear. The response of the group to the therapist attested to the comfort and support the group felt upon having others validate the vernacular in which their feelings were being presented.

The members also mentioned that certain dreams could be indicative of things that are going to happen. For example, one person said that when she dreams of flowers it means that someone she knows is going to die. She stated that these things happen so often that she wonders at times if she is crazy.

Another member responded by saying that these things come from the outside and these thoughts afflict people, and that at times it is better not to say anything because people say that one is crazy. The same person stated that the last time she went to Puerto Rico and talked to her relatives about these things, they thought she was crazy.

The therapist told the group that what they were describing was their internal dialogue with themselves and

that this dialogue would be present the rest of their lives. The therapist explained that this internal dialogue is communicated at many different times. She explained that often these dialogues come when the demands from the external world do not match the expectations and needs we have internally. Often, in the midst of these dialogues and struggles, we feel we have problems and get depressed. That is not necessarily craziness but a manifestation of internal battles that we often have.

The intervention by the therapist validated what the group members were presenting. Further, the therapist offered another way of understanding their experiences. The therapist suggested that these experiences should be talked about as they could lead to more stress when they are not expressed. The therapist continued, "Often, withholding these feelings causes some of the physical afflictions that some of you might have. At some point, your body just gives in."

Then a group member told how that she had been restless for days. She had an extreme pain in her waist, and thought that it was related to her son, who takes drugs. The therapist told the group that internal pressures are often like a pressure cooker that is ready to explode. One client responded that at times she feels like crying but is afraid to let go.

Toward the end of the session, the group members discussed situations in which they felt frightened. The therapist ended the session and encouraged members to think about the internal dialogue that may be going on whenever they have experiences such as the ones they had discussed.

The therapeutic orientation of therapist in this session was to work with the clients' presentation of problems as they understood them. The type of environment provided in this session encouraged clients to explore other ways of articulating and understanding their struggles. At no point did the therapist challenge the client's frame of reference. Rather, their frame of reference gave the therapist a starting point for therapy.

Case #3: Support Network

This case example is derived from the observation of a meeting of the Depressed Women's Group. This group meets on Thursdays and is composed of eight members. All of the members are first-generation Hispanics who have had some history of depression and/or psychiatric hospitalization for depression. The session lasts an hour and a half. The age of the members ranges from 30 to 66. The therapist leading the group stressed several times that this group is characteristic of the strong support found among Hispanic people. The therapist explained that often when a member cannot attend a session, the group will meet at that person's house.

The therapist opened the session by discussing a member who had been sick for the past three weeks. Two weeks ago the group had met at her house. A group member stated that she has been cooking food for the sick person and that before coming to the center she had brought her food and she seemed to be doing much better. Two other members reported that they had called and also felt she was doing better. They also wondered about two group members who had not yet arrived.

The therapist then asked the group for their permission to be observed through the one-way mirror for the purpose of the study. The group unanimously agreed to be observed and also invited Jose Reyes into the therapy room. The therapist, however, said that it was preferable for the observation to be done behind the mirror. They had previously discussed this situation and agreed that if it did arise, it would be better for Jose to remain behind the mirror.

A member then entered the room with her child 15 minutes late. Two minutes later another member entered. The therapist asked the two newcomers for their permission to be observed and they said that it was fine with them. Members said that at some point they would like to meet the person behind the mirror. The therapist suggested that this could be done at the end of the session. One member wondered out loud if the person behind the

mirror was attractive. The group joked with this member and told her that they could see she had ulterior motives.

This initial introduction to the group portrayed the close-knit support developed by these women who have the same cultural background. The therapist's role was to maintain the support which already existed in the group.

The therapist asked a member about her mother who was sick the week before. The client said that her mother was better this week and that her sister was taking care of her. The therapist then questioned a client about missing an appointment with the psychiatrist to obtain medication for her depression. The client said that she had forgotten the appointment and the therapist asked the client to write things down so that she will not forget the next time. A group member suggested that she forgot the appointment because she is scared of seeing the psychiatrist. Others in the group told the client how easy it is to forget things when one is scared.

As a follow-up to the previous week's session, the therapist asked a client to report on how she was managing in taking care of a member of her extended family. The client responded that no progress had been made and that she was beginning to feel more depressed. The therapist then told the woman that one can only take care of oneself and that the bottom line is for her to say "Enough" when she feels overwhelmed. The style of the therapist in this initial interaction can be described as directive and oriented to problem-solving.

Another member stated that the reason why it is hard for her to say when she has had enough is because she learned as a child that her role is to take care of her family. To the client, to do anything different would be going against what she was taught her role should be. The therapist said that to always do what is expected can be prejudicial at times. The therapist used herself as an example. Some days she leaves work early because she needs to do that for herself even though it does not match the expectations of others. As an active part of the group, the therapist used her own experience to validate the

suggestions that were being made by group members.

The therapist then directed the group to explore the feelings that are aroused by not doing things for themselves. She also explained to her clients that it is important to live in the present and not the past. A client explained that it is hard to forget the past and that often situations which happen in the present stir up feelings from the past. The woman said that she can recall as far back as when she was eight years old.

Another client said that she is becoming crazy because she can't remember much of her childhood. Other group members told this person that not remembering is common and happens to some of them as well. The therapist then attempted to connect this client's thinking to the group by saying that self-defeating messages often will complicate what and how people feel about themselves. By interpreting the client's concerns about being crazy as a cognitive message, the therapist provided her with a concrete frame of reference which reinforced the idea that being crazy is based on thinking and not being. The therapist directed the client to examine the self-defeating messages she was giving herself.

The therapist then turned to a group member and asked her, "How are things going with what you discussed last week about your father; how is he this week? Are you still getting five collect calls every day from your sister?" The client's sister lives in Puerto Rico with the father who has terminal cancer. The client had said that she was no longer sure she could pay for the calls, but that she couldn't bring herself to tell her sister about her predicament.

The client replied to the therapist, "Nothing, things are still the same, my sister is still calling me every day." Another member asked the client, "How about you calling and telling her to call you only twice a day?" Another person suggested that she should change her phone number and call her sister only when she wants to. The suggestion of getting another phone number was ignored

by the group. Another client suggested that she call the sister and tell her to call only if the situation gets worse or if the father dies.

The therapist asked the client to think about how often she wanted to be called about the condition of her father. Then the therapist explained that calls before seven in the morning and after eleven in the evening were less expensive. The therapist suggested that the client call in the morning and instruct her sister when and at what time she should call again to tell her about her father's condition. The client responded that she would try to do this next week.

At this point a member asked the therapist to admit the observer into the session so they could meet the "Psychologist" behind the mirror. The rest of the members agreed that this would be good so that they could answer questions directly about themselves. The therapist left the room and invited Jose into the session.

The invitation to enter the room and the ensuing dialogue with the group members further illustrate the support which the group extends to outsiders. Upon entering the room he was greeted by all the members. The therapist introduced him and asked if he had any questions. The first thing that came to him was to ask them their ages. The member who appeared to be the oldest replied jokingly, "Do you believe everything people tell you?" They all laughed and another member said, "We will tell you but you must realize that women are not sincere about their age." Then they started to count off systematically: 35, 34, 32, 29, 25, and everyone burst out in laughter. By now Jose had realized that his opening question had violated some type of norm, in the group. After the group got over the joking, they told him their actual ages, which ranged from 32 to 67. Then a member asked why he was at the center. He said that he was attempting to document what was done there and particularly what role the center played in delivering care to its client.

At this point the therapist turned to the group and asked if anyone would want to talk about why they had chosen to attend this instead of other centers in the community. One client replied, "The center that I was going to before did not have groups and they only had psychiatrists." Another member said, "I really like it here. I feel that the center where they sent me after I left the hospital was more for crazy people - you know people who were worse than me. My problems are more related to my family and myself and those people had different problems and definitely they were less able to cope than I was. Here this group is like a family, I can talk and I feel better." Another client said, "I also came out of the hospital and was referred here and ever since I have felt better." Another person said that she used to attend a group nearby where she would do things like sewing and ceramics. Part of being at that center included talking to a social worker but "She was not Hispanic and did not speak Spanish like they do at this center". The client stated that since attending the center and the group she has felt much better".

The therapist then suggested to the group that they attempt to outline some of other characteristics which they felt made this center different from others that they had attended in the past. A client responded immediately, "The center that I was attending before was only concerned with helping me deal with my daughter who was having behavioral problems in school. Learning things about how to manage my daughter did not help. What is good about this group is that I can be with people like me who understand many of the struggles that I have."

Another client said, "My problem has been my 'nervios' (nerves), and for months I went to a social worker but she did not speak Spanish. Eventually I quit going because all she wanted me to do was talk and that was very hard for me because I was embarrassed about speaking English. After a while they called me because of my absences and I explained to them on the phone that they were not helping me, so then they referred me here. They said, "We are going to send you there because at that

center they are Hispanic and you can cry to them in Spanish." Then she smiled and said, "I have always been a good 'Llorona' (weeper)."

A client then stated, "If I need any help I know that I can always call here. At other places like hospitals and private offices if you need help right away they cannot see you unless you have an appointment days, sometimes weeks, in advance. Here I call and they tell me to come in the same day."

The next client said, "My daughter had a problem and I could not accept it; after a year it began affecting me to the point that I got depressed. The hospital sent me here. Aside from my daughter's problem, I had therapy for my nerves because my ex-husband was alcoholic and this really affected me". The therapist inquired how her daughter was doing and the client replied that she was much better.

The therapist then asked the group to count off the number of years they had been living in the United States. They counted off around the circle: 20, 45, 35, 20, 26, 35, 40 and 16 years. The group also said that they were all natives of Puerto Rico.

Then the therapist asked, "Now, do any of you have any questions for him?" A client immediately asked, "I want to know why is it that one forgets things." Another group member replied, "That's not a question about him and that is not what the therapist inquired." One member asked, "Are you going to stay here (referring to staying to work at the center after the study is completed)?" Jose replied, "No, I am here conducting a research project and I will return to Cincinnati when it is completed." A client replied, "You probably don't like it here (referring to the city)." He explained, "I have my home in Cincinnati and I am pretty much established there." "Do they have many Hispanics there?" one client asked. He replied, "Not too many." Another client asked, "Where are you from?" "From Bayamon" (a city in Puerto Rico)," He replied, and suddenly they asked,"Ah what is your last name?" "Reyes," He answered. Then they began to tell him about

their visits to Bayamon. Some even named specific streets in Bayamon where some distant relatives lived. Their next question was, :"How long have you lived in the United States?" to which he replied, "About 15 years." Then the therapist thanked him as a cue that it was time to finish. He immediately got up and the group said goodbye as he left. The group left immediately thereafter.

This session provided a view of group cohesiveness and support important in networking among Hispanics. The provision of such a group at the center matches the expectation of support networks characteristic of Hispanic culture. This case also illustrates that the method of conducting research was affected by the support which migrants extend to outsiders.

Case #4: Migration/Support Network/The Spiritual Element

This case is drawn from an individual therapy session. A female client has been receiving therapy for the past six months. She was referred to the center by a nearby city hospital for treatment of depression. The client is divorced and has been living alone with her son for 18 years. The depression was precipitated by her son's acceptance to college out of state. In therapy, the client has been dealing with her feelings of abandonment and fear of the unknown after her son leaves home. The therapist reported that the woman migrated from Puerto Rico after being married for a year. Reasons for the divorce were not discussed. The client is a registered nurse and works at a nearby hospital.

The client entered the room and sat across from the therapist. The therapist initiated the session by saying, "I can feel your anger. What's going on with you? I feel there is something behind your anger."

The client explained that she is afraid to go to work. The therapist told the client to explore what she is feeling in the here and now. The woman replied, "I feel fear," and began to cry. The therapist moved her chair closer to

her client and held her hand. After the therapist touched the client, the intensity of the crying increased. The woman then told the therapist, "When I was 12 years old, I was told that I would be alone in this life. I always have to suffer by myself. She (referring to a spiritual advisor) told me that I would be unhappy in love, that is why I never married again. Today I consulted with this man (another spiritual advisor) and he told me the same thing over again." The therapist replied, "That is all true, but you have the responsibility to deal with the way you feel. Often the anger that you feel keeps you from reaching out to those who can help you. Let me ask you, "Why do you come?" The client replied, "Because you help me."

The therapist's intervention drew the client out to work with how she feels. At no point in the session did the therapist question the legitimacy of visiting a spiritual advisor. The therapist explained to the client, "You come here to talk about your feelings and asking for help is a step in the right direction. Often you seek people who do not help you and leave you feeling worse (referring to a friend the client had talked about in a previous session)."

The client replied, "The man I visited today for advice said the same thing. He said, 'You are hard on yourself and the people you seek do not help you but make it tougher on you.' I always ask God to take all these feelings out of my mind; sometimes I think that people are afraid of me because of my temper." The therapist asked, "Do you feel that I am afraid of you?" The client replied, "No, because you know me."

Because of her depression, the therapist asked the client, "Do you think that you need to be hospitalized?" The client replied, "No, I can deal with this out here, but if some day I go to the hospital because of the way I feel, I think I will kill myself."

The client went on to explain, "You know, I was OK while Dona Pastora was alive, she knew a lot." Dona Pastora was a well known spiritist who lived in the same community and died two years ago, as reported later by the therapist.

The therapist encouraged the client to think about the "Buenos consejos" (good advice) that Dona Pastora gave her to help herself. The client went on to say, "The last time I saw Dona Pastora she told me that I would have two children and would end up retiring from the hospital where I am now working. I have one child and I am still at the same hospital. Even though I miss her I can remember her words of encouragement."

At the end of the hour, the therapist directed the client to check back with her the following day by phone and made another appointment.

Conclusion: Delivery of Therapy

The cases in this chapter are representative of those presented by the migrants who attend the center. In many cases, clients have developed support networks after seeking help from spiritual advisors. The spiritual help that clients receive is considered legitimate in the delivery of therapy. The therapist validates the advice given by spiritual advisors and then moves the client toward the goals of the therapy session. In all cases documented, the client's belief system was respected. The provision of services is based on client need. For example, if a client needs supportive financial services, the therapy is oriented to get the client to the proper agencies for financial aid.

After observation of the delivery of services by the treatment team, it was clear that the research should also include an insider's view about the work performed at the center. To this end, informant interviews were scheduled with the treatment team to get their views on their orientation in providing mental health services to their clients. The next chapter describes these interviews with the therapists about what is provided for migrants and how it is delivered.

CHAPTER VI

IDEOLOGY AND THERAPY: AN INSIDER'S VIEW

The data presented in this chapter are derived from interviews with clinicians regarding their perceptions about what therapy is provided to the migrant and how this is accomplished. Four interviews were conducted with four therapists at the center, with each interview lasting approximately one hour. The first informant was a female Venezuelan migrant who has been practicing therapy in the United States for approximately five years. She has a Master's degree in counselling earned in the United States. The second informant was a female Puerto Rican migrant who has been practicing therapy in the United States for approximately seven years. She holds two Master's degrees: one in education from Puerto Rico and the other degree in Social Work from a university in the United States. She maintains current certification as a social worker. The third informant was a licensed psychiatrist who received his university degree in Puerto Rico and has been practicing in the United States for over 10 years. The fourth person interviewed was a licensed psychologist. After migrating to the United States, he completed a Ph.D. in clinical psychology. Currently, he is the program Director of the center. He was selected as an informant because of his extensive experience in working with migrants.

All interviews began with a short audiotaped segment of a group therapy session in which first-generation Puerto Rican women were discussing apparitions of the dead. This group has been meeting for over two years, with many of the original members still attending. In the tape played for the informants, the group discussed apparitions of close family members who had died and come back to the material world in an attempt to communicate with the living. Consistent with spiritist theory, spirits who are still in purgatory attempt to enter the material world to ask forgiveness from the living for past misbehavior.

Data from these interviews were classified according to themes: culturally specific problem presentation, client's expectation of therapy, therapist's views of client's problems, therapist's views of migration and acculturation, the therapist as a cultural individual, the role of the therapist and treatment orientation.

Culturally Specific Problem Presentation

This section discusses informants' approaches to understanding problem presentations by clients. The mode chosen by clients to express their problems is understood by the therapists to be culturally specific. Informants used the term vernacular to describe the client's culturally specific belief system in which problems are presented. As explained by one of the informants, "While the vernacular chosen by the client may differ from that chosen by others, the underlying psychological processes and presenting problems are seemingly universal."

Informants stated that accepting the client's belief system or vernacular leads to therapeutic engagement: the authenticity of the client's belief system is never questioned. For example, in the case of apparitions, the therapist can direct the client to pray, a recommendation consistent with the client's belief system that apparitions are not material and, therefore, prayer is appropriate to deal with the problem. This example illustrates a therapeutic intervention which involves both the acceptance of the clients's belief system and an engagement with the client for further exploration of problems. One therapist explained that the client's belief system is used to further the therapeutic process and that statements are not interpreted outside the client's belief system. Another informant stated that in the therapeutic context, perceptions and beliefs may be different from those of the therapist and should be accepted as long as they are not harmful to the client.

According to the informants, the atmosphere provided at the center encourages clients to present problems in a vernacular which is based on their belief systems. They

added that at the center clients can express their own beliefs because of a supportive therapeutic environment. A supportive therapeutic environment is described as one which allows clients to express their beliefs without having negative interpretations placed on them.

As explained by the informants, in many instances Hispanics who are referred to mental health centers often do not attend therapy for two primary reasons. First, the centers to which they are referred are not culturally syntonic; that is, the values found in these centers are not similar to those held by the clients. Second, therapists in these centers are not culturally sensitive; therefore, they attempt to persuade clients to work outside their belief systems. Ignorance of the belief system of clients often results in misunderstanding the experiences and perceptions of the migrant. According to informants, nonculturally sensitive therapists are quick to diagnose severe psychopathology in clients who do not fit their own belief system.

According to informants, the clients who attend the center are first-generation migrants, and the beliefs which they bring to the center have common themes. An informant explained that the tape played at the beginning of the interview was an example of commonality between belief system and culture. Another informant explained that the group session presented in the tape was indicative of a therapeutic environment which allowed clients to express a belief system common to the many migrants. The expression of this belief system, said one informant, represented a language of inclusion which furthered the development of a cohesive therapeutic environment.

Informants related the themes of death and apparitions to the feeling of loss which migrants experience through the process of migration and acculturation. According to the informants, the process of migrating and encountering a different culture produces a sense of loss. In providing clients with the opportunity to talk about their perceptions, an opportunity is also created for clients to begin talking about their losses.

In discussing therapeutic interventions and the presentation of a client's belief system, the informants explained that the therapist has at least three options. First, the therapist could restate the client's original statements as feelings. Second, the therapist could respond to the client in psychodynamic terms using concepts such as id, ego or superego. Third, the therapist could join with the client by following the chosen vernacular and expressing an understanding of the problem and its effect. All informants agreed that the third option afforded the therapist the greatest opportunity to treat the client.

In addition to apparitions, informants reported other themes presented by clients: clients explaining their problems as the consequence of bad luck, God's punishment or a curse someone has placed on them. Informants also reported that clients may use biological or genetic explanations for their life circumstances. For example, a client may explain her son's failure to achieve financial success in life as being a direct result of complications during childbirth. Clients' problems may also take the form of physical complaints, particularly among women who often complain of headaches and gastrointestinal problems.

Client's Expectation of Therapy

Clients generally enter treatment in desperation, wanting the therapist to tell them exactly what to do and to solve problems. Informants stressed that in the initial phase of treatment the therapist must carefully, yet clearly, establish reasonable expectations of therapy with the client.

Part of the therapeutic process is to help clients understand limits and assist them in establishing realistic expectations for their progress in therapy. Informants maintained that one of the goals of therapy is to convey to the client the benefits of attending treatment. With clients, therapists stress that the responsibility for change lies in their efforts to change.

Therapist's Views of Client's Problems

As reported by the informants, the typical client served at the center is the poor Hispanic. Most of the clients who attend the center are first-generation Puerto Rican migrants.

According to informants, depression is the most frequently cited reason for clients to come to the center. Informants viewed depression from several perspectives. Depression is viewed as being related to the sense of loss which accompanies migration, a feeling which can last nine to ten years after migration has occurred. It is also viewed as associated with past and present experiences of poverty, such as not being able to find adequate housing or jobs.

Therapist's Views of Migration and Acculturation

According to informants, the process of acculturation and migration needs to be understood when working with the migrant. Acculturation was defined as the approaches by which an individual retains as part of his or her old culture or adopts aspects of the new culture. One informant said that at some level, conscious or unconscious, where individuals are situated in the process of acculturation is determined by the values they choose to abandon and those they choose to adopt. According to informants, this process of loss and retention is common to all Hispanics who attend the center. From a cultural perspective, Hispanics in general go through a process of leaving and taking.

As presented by informants, the experiences of Puerto Rican migrants are different from those of other Hispanic in relation to migration and acculturation. Because of the commonwealth status of Puerto Rico, Puerto Ricans have a "Right of passage" to the United States - that is, they can come and go as they choose - but they are still migrants.

An informant explained this difference from personal experience. She remembers that as a child growing up in

Puerto Rico she always heard about the United States. In school English was taught and is still a required language. She explained, "Through language one was made to feel American." The informant went on to say that she never realized how Puerto Rican she was until she came to the United States. She said that because of the status of Puerto Rico as a colony of the United States, the process of loss which comes from migration is not often recognized, and that the "Right of passage" prolongs the process of acculturation. Other Hispanic migrants do not have this "Right of passage" and, therefore, perceive migration as a permanent change.

According to informants, many of the symptoms presented by clients at the center are in one form or another connected to the process of migration and acculturation. Women in general tend to have a shorter phase for acculturation than men, meaning that they show a prompt incorporation of the values of the new culture. This rapid acculturation in women relates to child rearing. As principal caretakers, women come in contact with the ways of the new culture through their children's encounter with the English language and with new values at school. Men often work in settings in which Spanish is spoken and the values of the Hispanic culture are present.

According to the informants, migration and acculturation are processes experienced by both clients and staff. Informants reported that socioeconomic levels and value orientations presented by clients were often familiar to staff. This familiarization and commonality of experience with clients was considered by informants to be an important ingredient in understanding and proving adequate services to the migrant.

The Therapist as a Cultural Individual

All informants emphasized that the experience and cultural background of the therapist is a major variable in the treatment of clients at the center. Informants explained that background similarities between clients and therapists foment the therapeutic process. An informant explained that she grew up at a low socioeconomic level

similar to that of the clients served at the center, and that the experiences of clients in adjusting to U.S. culture were similar to her own. Another informant related that in the process of adjusting to U.S. culture she was helped by many people; therefore, she views therapy as the means to help others make a transition to this culture as she did at one time. This informant concluded by saying that the most important qualities of a therapist are respect for the worth of a human being and the belief that almost every client is capable of making progress.

According to the informants, however, it does not take a migrant therapist to be able to work with migrant clients. There was consensus that by being of Hispanic background, one achieves an empathy and understanding from one's own experience which have no substitute. Identification with the group one works with and personal experience are vital to work effectively with these clients.

The Role of the Therapist

The role of the therapist, as described by the informants, is to present a different world to clients, to provide an avenue through therapy to empower, educate and offer alternatives to clients.

The role of the therapist was viewed by informants from different perspectives. The role of therapist in delivering services was defined as understanding the social perspective and condition of clients. For the poor, alternatives are often limited due to lack of financial resources; however, this should not lead to labeling the poor as unable to get ahead.

An informant stressed that the role of the therapist was to help clients develop "Dimensionality" meaning the ability to move from and to the Hispanic or Anglo cultures depending on environmental demands. In the application of therapy, this concept means to teach clients the ways of the new culture for the purpose of facilitating acculturation.

Another informant explained that the role of therapist was to join clients for the purpose of alleviating sources of stress. She explained that change through therapy occurs when the therapist relates to clients at both a personal and a therapeutic level.

Treatment Orientation

In regard to treatment orientation, informants placed emphasis on the need for the therapist to understand the impact of migration and acculturation on families and individuals. Informants stated that encountering a different culture also means adjusting to different value orientations. This process causes stress and a sense of loss. An informant used her migration experience as an example. When she migrated from Puerto Rico, she experienced great stress and loss of the familiar. The hardest thing for her to get used to were the new values around sex-role expectations. For example, the Anglo meaning for the term "Macho" is different from the Hispanic meaning. "Macho" in the Hispanic sense means assuming responsibility and willingness to carry out the duties which pertain to the role of being a male, such as providing financially for the family or catering to a spouse. Another informant explained that "Macho" in Anglo culture is a very abstract concept and is represented by Rambo and Oliver North. As explained by informants, the danger for Hispanics is when they do not accept the new values as their own. As a result, Hispanics not holding Anglo values may be labeled as inferior.

All informants agrees that the goal of therapy is to empower clients. Informants explained that it is necessary for therapists to be able to work in both cultures. They also believe that therapists must be able to adjust their orientation to the culture of the client, rather than to make the client adjust to the culture of the therapist. One informant used the concept of "Cultural elasticity" to explain this approach. She explained "Elasticity" as the ability to work in the mode of the Anglo Culture, as well as the Hispanic culture in particular situations. Another informant said that "Elasticity" was acculturation and that this meant knowing both cultures. Informants agreed that

an acculturated therapist can give clients the reality of the two cultures they experience through migration.

According to the informants, the view which states that Hispanics are poor candidates for psychotherapy is more stereotypical that factual. One informant warned against the danger of labeling poor Hispanics by using a personal example. The informant talked about an instance in which she found herself stereotyping a client in therapy. The client, who was receiving welfare, presented herself to therapy asking, "I wonder what it is like to be happy?" The informant explained that her immediate reaction was to think that the unhappiness of the client was because she was dependent on the welfare system. Through what the informant called the process of "Historical validation," she was able to learn the client's history and understand that the welfare system was an appropriate avenue for the client given her circumstances. Through the process of therapy the informant came to understand that the problem presented by the client was not due to being on welfare.

Informants stated that they varied their therapeutic style. There was no indication of a particular mode being more engaging to clients than another. One informant responded that the eclectic style she used followed rigid lines on ego psychology and the development of individuation. Another informant said that she tended to conceptualize all clients in relation to the larger system, meaning that individuals are affected by and in a constant dynamic interaction with the environment. This informant described herself as a systems-oriented therapist.

All informants reported using several modalities depending on the need of the client. These included: task-oriented therapy (behavioral task interventions), directive therapy and systems therapy (bringing family or extended support systems of the client to the therapeutic setting). There was consensus that psychoanalysis did not fit the expectations of therapy held by their clients.

In sum, therapists treated migration and acculturation as the major precipitants for clients to enter treatment. The therapy described by the informants allowed clients to express their problems within their own belief systems. The beliefs of the client were never questioned but used to further the therapeutic process. Therapy was viewed as an avenue to help migrants through the process of acculturation.

The next chapter presents conclusions, integrates the findings and discusses the implications for creating a culturally relevant program for Hispanic migrants.

CHAPTER VII

CONCLUSIONS

The literature on the treatment of the Puerto Rican migrant points to the need to develop relevant programs which fit the specific needs of the migrant. This ethnography study presents first-hand information on a mental health center which was developed to meet the needs of the Hispanic migrant. This study focuses on describing the structure of the center and the treatment modalities used in delivering services to the migrant. It was found that the services provided at the center were culturally specific to Hispanic clients. Although the treatment offered to clients was standard, treatment was characterized by cultural bonding between the client and therapist.

Structure of the Center

The center is strategically located in a low-income neighborhood composed primarily of Hispanic migrants of Puerto Rican descent. The location of the center provides easy access to the migrant. The physical aspects of the center are representative of the cultural background of the people it serves. All staff who deliver services are bilingual and bicultural, meaning that all are themselves migrants or children of migrants.

The center, although established as a mental health center, provides services which go beyond this sphere. Services also include assisting clients to obtain appropriate housing and financial help. These services are provided by personnel who are themselves migrants and know the processes of cultural adjustment. The services offered to the migrant attempt to remedy environmental factors which are believed to disrupt mental health. The provision of such services has been suggested in the literature (De La Cancela, 1985a, 1986a; De La Cancela et al., 1986b; Galper, 1978; Montijo, 1985). This literature stresses that mental health is highly related to environmental conditions and restraints. This literature also advocates social change as a component in the

services provided. For example, De La Cancela (1985a, 1986a) and De La Cancela et al. (1986b) suggests that a relevant psychotherapeutic approach with the migrant must address social and environmental struggles which face the migrant, such as finding adequate housing, connecting with community support networks and providing services in an environment which is culturally syntonic, meaning where language and culture are familiar to the migrant.

Consistent with this recommendation, the center was oriented to meeting the migrant's needs by dealing with environmental factors such as inadequate housing and unemployment. At the center, the migrant can speak either Spanish or English. Other aspects of the center which provide a familiar environment to the migrants are the use of food, the acceptance of cultural beliefs such as spiritism and the presence of value orientations of both Anglo and Hispanic cultures.

Meaning of Food

Food was present at most activities in the center. It was an integral part of administrative meetings, staff meetings and therapy sessions. The connectedness provided by food was most evident in therapy and staff meetings.

Food is an integral part of the Hispanic culture. When one pays a visit to an Hispanic friend or family it is often expected that the guest will be offered something to eat. Turning down food in Hispanic culture is often considered impolite and rude.

Food provides a means of connecting, accepting and welcoming others into one's home. By allowing the introduction of food, the center enables clients to find acceptance and bonding in a setting where cultural values are similar to their own.

Spiritism

The cultural belief in spiritism has been recorded in the literature as a common characteristic among Hispanics. Delgado (1977) has written about the acceptability of spiritism in the Hispanic community and has suggested that programs attempting to serve the migrant incorporate the use of paraprofessionals. According to Delgado, paraprofessionals can help the therapist as consultants in understanding cases in which spiritist beliefs are present. Delgado has gone so far as to suggest that spirit mediums should work closely with mental health professionals in some cases.

There are no professionals at the center to provide spiritist consultation, but the nontherapist staff do provide information on spiritism. In any case, spiritism is a belief that is accepted by all staff. In working with clients, spiritism is interpreted as a culturally specific vernacular which provides clients with an avenue for articulating their conflicts. Spiritism is discussed openly in sessions by clients without fear of the therapists imposing diagnoses or their own interpretations on these belief systems. The acceptability of spiritism creates a supportive therapeutic environment which provides comfort and acceptance and encourages clients to attend therapy and express their own experiences in a way which is culturally familiar.

Value Orientation and Treatment

Value orientations of both Anglo and Hispanic cultures are present at the center. For example, in the delivery of services to the migrant, therapists often present clients with the dichotomy of both cultures and appropriate ways to meet their needs through knowledge of Anglo values. Learning the values of the new culture is a topic often discussed in therapy sessions and staff meetings.

Acculturation as presented by staff is the process of both retention of the Hispanic culture and incorporation of the newly encountered Anglo culture. The process of acculturation affects the individual, the family and the

entire value system typical of Hispanic culture. The value orientations of the clients are based on expectations within the Hispanic culture and its focus on family life, child rearing and clearly defined sex roles. Upon migrating to the United States these values are challenged as the process of acculturation begins. Having to adjust to a way of life with a different value orientation often leads to conflict and stress. For example, in the Hispanic culture the task of child rearing falls upon the woman. Upon migrating to the new culture, women often have to go to work in order to supplement the household income.

This is also complicated by the rapid acculturation of their children. Already in a stressful situation, women are often unable to hold on to the value orientation of child rearing as dictated by the Hispanic culture. Consequently, these new demands lead to mental health problems. Often the conflict leads to the expression of symptoms through a vernacular based on the values and beliefs of the culture of origin. A case in point is the renowned Puerto Rican syndrome - also known as "Ataques" (attacks). Given the process of stress and disruption produced by acculturation, "Ataques" can be viewed as a culturally specific avenue selected by the migrant to express the conflict brought about during the process of acculturation. To help the migrant through this process, the center incorporates a treatment modality which takes acculturation into consideration.

Treatment Orientation

The importance of the process of acculturation and its impact on mental health are emphasized in the literature by Inclan (1980, 1983, 1985). This literature suggests that many of the mental health problems presented by the Hispanic migrant are linked to the process of acculturation. The same literature proposes that mental health workers aid the migrant in acculturation by facilitating the process. For example, the therapist could explain to the client the values of the Anglo culture in relation to Hispanic values, or connect the stress and conflict experienced by clients to the process of acculturation.

The structure and therapeutic orientation of the center are directed toward helping the client through the process of acculturation. Interpretations of stress, behavioral interventions and therapeutic diagnosis take into account the pressure which clients experience. Both in training and application, the center uses systems theory to work with individuals and families. Systems theory as it relates to family therapy addresses the entire family during the treatment process. This approach to treatment deals with the resolution, at the family level, of the impact caused by the process of migration. The focus on family therapy also includes the negotiation of new values which have impacted on the boundaries and role hierarchies of the family system (Inclan, 1985). For the migrant, involvement of the entire family in treatment serves as an avenue of support (Canino and Canino, 1980; Christensen, 1977).

The integration of the family into treatment has two major therapeutic values. First, by working with the family in treatment the center connects migrants with their primary cultural source of support. Second, this method provides the family with the opportunity for mutual understanding of the impact of migration, acculturation, value orientation and stress which result upon encountering a new culture. Therapy then becomes a negotiating avenue for the family to begin a dialogue on changes which are taking place as a result of the acculturation process.

A second major therapeutic modality used at the center is group therapy. Group therapy provides the migrant with a network of support, the opportunity to share common experiences within the same cultural context and the opportunity to express discomfort and stress in Spanish. As pointed out in the literature, support networks are essential in the Hispanic culture (Christensen, 1975). It has also been found that verbalization of feelings in a second language often brings little cathartic relief to clients (Marcos, Alpert, Urcuyo and Kesselman, 1973). Moreover, the use of Spanish or English by the therapist needs to be looked at in relation to effectiveness in working with the migrant. It would

seem that the more fluent the therapist is in both Spanish and English, the more this ability would enhance the therapeutic relationship. The more the therapeutic relationship with the migrant can be enhanced, the more likely it is that the therapist will be able to provide culturally based treatment.

Therapeutic Techniques

The bonding techniques used at the center with clients are consistent with the literature on the development of therapeutic relationships (Hammond, Hepworth and Smith, 1979). These techniques involve reflective messages, empathetic messages, mirroring of feelings to the client and close physical proximity to clients. Given these therapeutic techniques for bonding with clients, therapy then reflects sensitivity for cultural values and client needs. The client's problems are approached from a culturally specific framework.

Practical Implications of the Study

This study has implications for the development of mental health programs for Hispanic migrants in the United States. Specifically, there are implications regarding treatment staff, how treatment is provided, what type of treatment is provided and what therapeutic orientation to use when working with Hispanic migrants.

Treatment Staff

There are implications that a culturally sensitive program should conside. he hiring of treatment staff who are bilingual and bicultural. Given the disruption which accompanies the process of acculturation, it would also seem helpful to have a staff which has experienced migration. A migrant staff may provide a more insightful assessment to clients on the process and impact of acculturation. This does not imply that one Hispanic migrant must treat another Hispanic migrant. It does imply the importance of a thorough cognitive and emotional understanding of the process of migration and acculturation and how it relates to mental health

treatment. Given adequate funds, treatment centers can provide training to mental health professionals on the cultural aspects of Hispanics. In addition, monolingual mental health workers would be advised to gain competency in the Spanish language.

Treatment

Since cultural beliefs cannot be mandated, the emergence of a culturally sensitive treatment program must come from within the structure itself. The establishment of a treatment program for Hispanics must take into consideration the values of the population it serves. For example, the structure of the center's program contains the following features that are representative of the culture of the clients: acceptance of food, acceptance of spiritism as an avenue to express conflict, understanding of acculturation, providing services to clients which go beyond traditional services offered at mental health programs and the availability of a bicultural and bilingual staff.

Another important aspect of a culturally sensitive treatment program involves the legitimation of paraprofessional staff. For example, nonprofessional staff could be trained to participate in the treatment of clients through the use of their knowledge of the culture. The utilization of nonprofessional staff in the provision of services must be adequately addressed in the funds provided and these workers should be compensated adequately. In addition, training would also be necessary to improve the quality of the services they would provide. Without training, acknowledgement and proper compensation this personnel would run the risk of being exploited.

Allowing paraprofessionals to become active in treatment would result in less hierarchical power arrangements among the staff. This structure would also serve as a model for clients of relations of mutual respect and less unequal distribution of power distinctions based on status. Thus, the power structure presented to clients may encourage them to develop their own sense of

empowerment. More practically stated, instead of thinking of themselves as inferior to the hierarchical structure of the center (and the larger community), clients may begin to see themselves within the structure of a system which allows them to establish a more equal status.

Therapeutic orientation in working with the migrant must accommodate both the physical and emotional needs of the client as a primary focus. The therapeutic intervention required for a client suffering from depression must deal with the presenting problem of inadequate housing. An adequate intervention means guiding the client to the proper channels for obtaining better housing. Treatment means using the clients' practical needs as an avenue to engage and therapeutically help them. This follows the belief that treatment should empower people rather than move them in a direction that may be more acceptable to the provider.

Future Research

The methodology applied in this research suggests that information about how programs function may be gathered to understand the process of providing culturally relevant treatment. It should prove useful to continue to conduct qualitative studies to supplement the quantitative methods used in program evaluation, treatment evaluation and therapeutic modalities applied with culturally specific groups.

Comparative analyses of using this study as a point of reference with other programs established to serve minority populations may prove useful in understanding culturally sensitive treatment of minority groups in general. Similarities and/or differences in the provision of culturally sensitive treatment programs may give new insight into the development of a more encompassing theory of treatment of oppressed groups in general, rather than theoretical development with respect to each separate minority group.

Finally, several aspects brought in by this study require further qualitative analysis. It presents the type

and methods of treatment found at a mental health center developed specifically to serve the Hispanic migrant. The question of effectiveness still remains to be answered from a program evaluation perspective. This study presents minimal views on why clients attend the center under study as opposed to other centers. Needless to say, in reading the client responses of why they attend the center one has to about on the culturally sensitive treatment provided at the center for clients. However, this study does not deal with determining the effectiveness of the center. Utilizing those aspects of this study that have identified critical components of this program will offer direction for future research concerning the specific facets which are important to explore in program evaluation. Many such facets, such as the role of paraprofessionals, the use of culturally specific traditions, (e.g., food) and the treatment orientation to acculturation have been largely ignored in previous evaluations that do not reflect the critical components of a culturally specific program.

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